EXHIBIT 9

The Center for Headache, Spine and Pain Medicine
A multidisciplinary approach focused on pain relief and functional rehabilitation.

Ezekiel Fink, MD, QME
Board Certified in Neurology and Pain Medicine

Patient's Name: [redacted]
Date of Birth: [redacted]
Date of Initial Exam: 02/05/2014
Location: Beverly Hills

INDEPENDENT MEDICAL EVALUATION

Mr. [redacted] was evaluated in my office on February 5, 2014 for an Independent Medical Evaluation (IME).

HISTORY OF FOOTBALL PLAY:

Mr. [redacted] who is presently 31 years old, started playing football at the age of 9 in a Community Football League and continued playing during high school. In 9th grade, he played varsity football and continued doing so for all 4 years of high school. He played on both sides of the ball; he played running back and linebacker. He experienced the routine sprains and strains of the game. He does recall having his "bell rung" one time and being taken out of the game. He missed no other games and required no surgeries in the course of his high school career.

He then went to Stanford beginning in 2000. In college, he became a linebacker and played many positions, including special teams, as a varsity starter. He began playing on the varsity team as a freshman; during that year, he sustained a right shoulder injury which later necessitated a surgery. He was medical redshirted after the shoulder injury in game 4 of that year and missed the remainder of the season. He had the surgery during his freshman year and then returned to play in his sophomore year. In spring practice of the sophomore year, he sustained an elbow fracture; his arm was placed in a sling and recovered over the course of several weeks. He recovered in time to be at full strength for training camp. Other than the routine sprains and strains of the game, to the best of his recollection, he played for that entire season. He does recall that there were several orthopedic injuries that were not fleeting, including a left high ankle sprain as well as bone chips in his ankles, which did limit his playing time at certain points along his college playing career. He cannot recall the specific details of exactly when these injuries occurred.

In game 1 of his junior year, he sustained a fracture in his left hand. He was casted and continued playing for the remainder of the season. He played through the remainder of that season with the routine sprains and strains of the game but did not miss any substantial playing time. In his senior year, he played the entire season without any substantial injuries. He recalls having his "bell rung" one time in a kick-off return during his junior year.

The patient completed college and was drafted by the Cleveland Browns in 2004. He started on special teams and played through the pre-season. In the first play of the regular season, he sustained his first concussion in the NFL on a kick-off return. He recalls placing a hard hit on his man and feeling disoriented; he describes it as if he was looking into the sun. Even though the play was still going on, he began walking back towards the sideline. He was not taken out of the game and kept playing through the injury. He continued playing on special teams and was a rotation player for the regular downs for the last 5 games of the season. There were no major injuries to the best of his recollection for the remainder of that season.

In the pre-season of 2005, he was wearing modified protective knee braces along the outside of his knees. The brace on the left knee was not functioning properly and in the course of the practice, he felt like his left knee "needed to pop". It was thereafter that he began developing chronic knee issues, including episodic swelling of the knee and pain. In the last pre-season game against the Chicago Bears, he made a move and his left thumb got trapped in the offensive lineman's mask while approaching the quarterback; this resulted in a traumatic fracture of the left thumb. He was placed on injured reserve (IR) after this for the entire season as he recovered from these injuries. He did have microfracture surgery performed on the left knee during this time as well.

In 2006, he was waived by the Cleveland Browns during the off-season and was picked up by the Denver Broncos during the off-season. He played with the team for the pre-season through the regular season. He was on the practice squad with the intention of being activated in week 3; however, during the practice preceding his being activated, he sustained an injury to the right knee. An arthroscopic knee surgery was performed during the 2006 season, and he underwent rehabilitation. He was able to rejoin the team during the regular season after 6 weeks. He remained on the practice squad for the remainder of the season due to the knee injury and subsequent rehabilitation.

In 2007, he rejoined the team for the pre-season, played the regular season as a regular starter for 5 games, and was then waived. He was picked up by the Baltimore Ravens and finished the season as a rotational player for the remainder of the season.

In the 2008 season, he rejoined the Ravens. He played with them through the pre-season and was cut immediately prior to the regular season beginning ("last cut"). He was then picked up by the Carolina Panthers; during a practice with them, he injured his left hip/adductor muscle. He was then cut by Carolina. Subsequently, he worked out with Jacksonville and Tennessee. He was picked up by the Tennessee Titans around week 6 and remained on the practice squad for 7 weeks prior to playing the last 2 games as a rotational player. He does recall starting one game. The Titans cut him prior to entering the playoffs, and the Philadelphia Eagles claimed him off waivers. He could not play with the team in the playoffs; rather, he had to wait for the subsequent season to join the team.

In the next season, he joined Philadelphia for off-season workouts. Immediately before a mini-camp on May 25, 2009, he ruptured his left Achilles; the team kept him on IR until another linebacker was picked up in the pre-season, at which point the team settled out his contract. He subsequently had an Achilles tendon surgery in 2009. The patient then rehabbed from the Achilles injury and began to recover.

He recalls that for the 2010 season, he was picked up by the New England Patriots several days before the draft. He went to the team's off-season workouts. He did have an episode where his lumbar spine "went out" while squatting. He had conservative treatment modalities and returned to practice after 2 to 3 days. After mini-camp in June, he was released by the Patriots.

The patient then joined the mini-camp in Tampa Bay, but that team did not pick him up. He then joined the Seattle Seahawks during the second week of the pre-season. He continued with Seattle through the pre-season but was cut during the "last cut". He then was picked up by the Titans for the regular season. He played for approximately 8 games as a rotational player for that team but then was waived. He then went to try out for the Houston Texans, who did not pick him up; subsequently, he returned and finished up the season with Seattle. He played 6 regular season games and 1 playoff game with the team. After playing the season with Seattle, the team did not renew his contract.

The following year, which was the 2011 season, he was picked up by the Kansas City Chiefs and played all pre-season games with the team. He had a left hip pointer during the first pre-season game. He only had conservative treatment modalities and no extensive workup was done, although he continued to have discomfort during the entire season on the left hip as a result of this. A week into the regular season, he sustained a bone bruise in the left knee. He did get X-rays of the knee, and there appeared to be some structural damage to the knee including some cartilage tears. In the course of the season, he also had a hip bruise on the right side. He also began having some left shoulder pain. He had an X-ray after the season was over, which showed some structural damage to that shoulder. He was told that it was a rotator cuff tear. Later imaging revealed

that there was far more extensive damage than just a rotator cuff tear.

In 2012, he participated in offseason workouts again with the Kansas City Chiefs. He had Synvisc injections done on both knees prior to beginning the pre-season with the K.C. Chiefs. The day before the last pre-season game in 2012, he had the Synvisc injections repeated because of the amount of pain he was experiencing in his knees. He was also experiencing worsening pain in his left hip at that point and was unsure as to whether it was due to an acute injury or a chronic problem. He missed the last cut with that team. At the end of his stay with the Kansas City Chiefs, he was experiencing chronic injuries. The team also told him that he did not pass the physical examination, and he was cut.

The patient then sought out an evaluation of his various orthopedic complaints and discovered that he had extensive anatomical problems in multiple parts of his body.

CHIEF COMPLAINTS:

1. Cognitive problems. The patient reports having short-term memory loss. He recalls that, frequently, he will have the experience of getting up to do a task but on his way to performing the task, he will lose track of what he got up to do. This is a recurring problem at this point. He also recalls returning to Stanford in 2013 to finish up his degree and having substantial difficulties with reading comprehension, where he could literally read a sentence and immediately not recall the content. He reports that he was previously a very proficient reader and had a real love of reading, and thus the loss of basic comprehension skills was a very scary experience for him; this unfortunately has been something that he has experienced on multiple occasions. He also reports having difficulty with visuospatial relationships. He gives as an example that he has worked in multiple parts of the country and has a very good sense of direction; he now struggles to determine where he needs to go. He also reports having difficulty with concentration, whereas before this was not an issue.

   The patient reports that he was slow to anger earlier in his life. However, with time, he has become very easily irritated and has a “short fuse”. He feels that his wife would support that description. The patient notes now that he does have a tendency to think about physically hurting people who aggravate him, although he is able to restrain himself.

   In general, the patient does not describe himself as being a depressed person. He is an optimistic person by his nature. He does report that he has developed depression, especially when he thinks about how his career with the NFL ended, the multiple injuries he has accrued, and the difficulty he has

been having in seeking the appropriate care for his injuries.

The patient was a result of a normal pregnancy and a normal delivery. The patient reports that there were no developmental issues. He did have a mild stutter which resolved itself. He also had childhood enuresis which also resolved itself. He was a very good student throughout school.

He did have several incidents of head injuries when he was young. There was one at the age of 6 and one at the age of 8. He still carries a scar on his right forehead from when he was spinning on a bar and struck his head against a pillar that was close by. He was bleeding, but there was no loss of consciousness. He also had an injury to the occiput on the right side that required stitches. He does recall a flash of light when it did occur, but there was no loss of consciousness with that injury either. The patient was in a motor vehicle accident at the age of 9, during which he sustained a whiplash injury to his neck. There were also speakers in the car suspended above the backseat that were not fastened down, and one of them hit him in the occiput when this motor vehicle accident occurred. There was no loss of consciousness with the event, although he was momentarily disoriented by it. He recalls being in other motor vehicle accidents that were less severe than this one and did not result in substantial head trauma. At the age of 10, he was riding a bike and fell off the bike, skinning the left side of his face. He vividly recalls sustaining this injury and injuring his face, so he is quite certain that he did not suffer a loss of consciousness. In addition, the patient grew up in a household that was of modest means, so he was picked on a lot for the clothes that he wore; for this reason, he got into multiple fights. This only occurred when he was younger.

The patient recalls sustaining concussions in the course of football play. He recalls a concussion while he was with the Denver Broncos; he was struck, his head moved laterally back and forth in a whiplash-type of motion, and he experienced the disorientation. He recalls that the disorientation lasted for 3 to 4 plays but that he was not taken out of the game. There were multiple plays where after receiving a big hit he was momentarily disoriented, although this was common and he would just play through it.

2. Head pain. The patient reports having pain radiating from the right occiput through the temple. He began having the symptoms in the same distribution on a very brief but painful basis when he was playing football. Since leaving football, the pain occurs in the same distribution but on a more chronic and regular basis. This pain occurs up to 4 to 5 times per week and can last 30 seconds at a time. He describes a sense of pressure with this that is holocranial. He reports having photophobia but denies phonophobia or nausea associated with this pain. In terms of his family history, his brother

does have headaches. However, he denies a prior personal history of headaches dating back to his youth or prior to his football playing days. The most severe headaches occurred in his playing days during the first several days of training camp. These were in an occipital neuralgia-type distribution which was symmetrical but also radiated to the apex of the skull.

3. Facial numbness. The patient reports having numbness and decreased perception in the left V1 through V3 distributions.

4. Hearing loss. The patient reports having decreased hearing perception in the right ear. He has noticed that he preferentially uses his left ear for using the phone due to the hearing loss on the right side. The date when these symptoms began was as far back as 2002.

5. Dizziness. He reports getting episodically dizzy if he stands up too quickly. This can be severe enough that he will have to sit back down in order for it to pass. He will episodically also have tinnitus, which is more severe on the right side.

PAST MEDICAL HISTORY:

1. Elevated triglycerides and cholesterol
2. Multiple orthopedic injuries
3. Mild sleep apnea and snoring

PAST SURGICAL HISTORY:

The patient had a Bankart and labrum repair on the right shoulder in 2000 with a Hill-Sachs lesion.

In 9/05, he underwent a left knee arthroscopy, partial medial meniscectomy.

In 2006, he underwent a right knee arthroscopic surgery for second degree LCL tear as well as a lateral meniscectomy.

On 2/14/06, Pierre Rivet, M.D., performed a submucous resection of the right inferior turbinate with left inferior laser turbinate reduction and CO2 laser palatoplasty with partial uvulectomy and intracapsular tonsillectomy.

He sustained a full rupture of the left Achilles tendon, which was repaired in 2009.

CURRENT MEDICATIONS:

Aleve p.r.n. He controls his blood lipid level with diet and fish oil.

DRUG ALLERGIES:

The patient is allergic to INDOCIN.

SOCIAL HISTORY:

The patient smokes a pack/5 cigars per week. This is a habit he has picked up over the past several years. The patient reports consumption of alcohol moderately over the course of his college career; otherwise, he is a social alcohol consumer. Beginning in college, he was an infrequent user of marijuana. This continued through his NFL career, and he gave it up approximately one year ago (he did find substantial pain relief from using this). He denies performance-enhancing drug/steroid use.

FAMILY HISTORY:

The patient's father has kidney stones, diabetes, and prostate cancer (5 years in remission).

Both of his maternal grandparents have diabetes. His grandfather controls this condition through his diet, but the grandmother has to take insulin.

His aunt has kidney disease and also sustained a stroke (she passed away one year ago from unclear causes).

Another aunt on the maternal side died from a berry aneurysm rupture.

A cousin on the maternal side died of a stroke.

A great uncle on the grandmother's side had cardiovascular disease that required a pacemaker and died of complications from this.

On his father's side, he has an aunt that passed away from colon cancer several years ago.

Another aunt on the father's side has kidney disease that requires dialysis.

His sister recently received a kidney transplant for early onset nephrosis syndrome. She was on stage 4 renal failure prior to the transplant.

His maternal grandfather does appear to have a memory impairment which may be dementia. This same relative worked in a nearby school system but was relieved from his duties due to a psychotic break at some point in the past.

His brother was diagnosed with bipolar disease.

WORK HISTORY:

The patient last worked while playing in the NFL and is currently not working.

REVIEW OF SYSTEMS:

Hand numbness. The patient reports that when he maintains a position for a period of time, he will have a glove-like distribution sensory loss in both hands. This occurs also while he is sleeping, but this is present more if he sits in one position for a prolonged period of time. Straining the elbow and moving his fingers will help improve this sensation, although it can recur without maintaining a regular position. As a result of this, this sensation is a regular occurrence every night; he will have to hold his arms over the bed in order to get it to resolve. On the left hand, he has a focal numbness reflecting a digital nerve injury, most likely in the ring finger on the radial side of the finger and on the index finger on the ulnar side of the finger.

Low back pain. The patient reports having axial low back pain with symptoms radiating down his legs. The pain is more pronounced on the left than on the right side. He has a chronic axial complaint and a radicular complaint that is more of an episodic shock-like sensation. The axial pain is 6/10 in intensity. The shock-like episodes are 8-9/10 in intensity. He reports having some focal weakness in the left leg, which is pronounced at the hip as well as in the calf.

Neck pain. The patient reports having a tight compressed-type sensation in his neck that actually feels as if the neck needs to be cracked. The symptoms are on the midline and axial in nature. The pain is 5-6/10 in intensity. He also reports having a clicking sensation and sound when rotating his head laterally.

Multifocal orthopedic injuries. The patient, as previously described, has sustained multiple injuries to his body. He reports that his knees in particular are very sensitive to barometric pressure changes. He reports having substantial stiffness, suggestive of an early arthritic problem which is multifocal. As he stands up, he will hear cracking in multiple joints. The patient reports having positional nerve compression symptoms in multiple parts of his body. This includes the left arm falling asleep and the legs falling asleep if he maintains a position for any period of time. He reports, for instance, that if he sits on the toilet for even a brief period of time, both of his legs will fall asleep. Similarly, if he sits on a chair in any type of position for a prolonged period of time, his legs will fall asleep. He reports having difficulty walking on uneven surfaces due to a gait impairment.

Sleep. The patient reports that he is not sleeping well at night, primarily due to anxiety and stress. He also reports that the pain contributes to his inability to get into a comfortable position. He has tried different mattresses, including getting a Tempur-Pedic, and although he has noticed the increased comfort of this type of mattress, it has not led to better sleep due to his multifocal complaints. He reports getting a maximum of 6 hours of sleep, although this can be quite fragmented. The patient played at a weight of 305 to 310 pounds. He presently weighs about 316 pounds. He feels that for the most part he maintained his muscle mass and tone, although the distribution of the muscle mass is somewhat different because he is focusing now more on low-impact types of exercise. He feels that he was snoring as early as 2003 or 2004. He has had a sleep study, and no OSA was identified. He has had his right nasal turbinate opened up, and he has also had an uvulectomy done to open up the airway. This has improved the air flow.

PHYSICAL EXAMINATION:

GENERAL: The patient is a well-nourished, well-developed male who appears his stated age. He is in mild distress but is alert and oriented x3. He gives a clear and coherent history. Speech is normal and fluent. Language is normal.

NEUROLOGIC EXAM:

The following was tested on a neurological exam; the pertinent findings are listed below:

II: Visual fields are tested.
III, IV, VI: Extraocular muscles are tested. No nystagmus. PERRLA.
V: Motor: Jaw open/close tested. Muscles of mastication tested.
Sensory: V1-3 tested to all perceptual modalities.
VII: Face symmetry observed. Orbicularis oculi and orbicularis oris tested. Smile tested.
VIII: Hearing is intact to whisper symmetrically.
IX, X: Gag, swallow, and phonation tested.
XI: Shoulder shrug tested.
XII: Tongue is normal with no fasciculations or wasting.

MOTOR:

Muscles tested:

Arms: arm abduction, arm adduction, elbow flexion, elbow extension, wrist extension, wrist flexion, finger extension, abductor digiti minimi, first dorsal interosseous muscle, opponens pollicis, and abductor pollicis brevis.
Legs: hip flexion, hip extension, hip adduction, hip abduction, knee flexion, knee

extension, foot dorsiflexion, foot plantarflexion, big toe flexion, and big toe extension.

REFLEX:
Deep tendon reflexes: Biceps, triceps, brachioradialis, patellar, Achilles and Babinski tested.

SENSORY:
Testing of pinprick, temperature, vibration, joint position sense, and light touch tested.

COORDINATION:
Finger-nose-finger and toe tapping tested.

GAIT:
Base, arm-swing, toe walking, heel walking, and tandem walking tested.

PERTINENT FINDINGS: Cranial nerves II through XII: The patient reports decreased perception in V1 through V3 distribution. He also reports having decreased sensation to finger rub.

Motor examination is 5/5 throughout. Tone and bulk are normal.

DTRs: Hyporeflexic but symmetrical. Toes are downgoing.

Sensory examination: The patient has decreased perception in a stocking-glove distribution to all modalities. He also has decreased perception in the bilateral C8 and left C6 distribution. The right C6 has normal perception. In the lower extremities, the patient has decreased perception in all modalities. He has preserved vibration sense to a greater extent on all of the modalities.

Coordination: There is no tremor present. There are no abnormal movements present.

Gait: wide based.

IMPRESSION:

1. History of football play
2. Headaches
3. Cognitive complaints
4. Hearing loss/dizziness/tinnitus
5. Chronic pain/orthopedic injuries
6. Behavioral/mood disturbance

DISCUSSION:

Mr. [redacted] was evaluated in my office on February 5, 2014 for an Independent Medical Evaluation (IME) of the neurologic sequalae that resulted from prolonged participation in football.

There are a number of medical records reviewed on this patient. A complete listing of the records follows the discussion section.

There are multiple records addressing the orthopedic injuries this patient sustained.

There is also a record of a sleep study revealing a mild sleep apnea syndrome and snoring.

This patient did have an MRI of the brain performed on 2/25/13, which revealed two areas that may reflect a traumatic hemorrhagic event.

Summary:

Mr. [redacted], a 31-year-old former NFL player who participated in football play for two decades, is experiencing ongoing cognitive impairment, headache, hearing loss/dizziness/tinnitus, and behavioral/mood symptoms after retiring from football play.

I am going to address the various neurological symptoms below:

COGNITIVE IMPAIRMENT:

Dementia is a disorder that is characterized by impairment of memory and at least one other cognitive domain (aphasia, apraxia, agnosia, executive function). These must represent a decline from previous level of function and be severe enough to interfere with daily function and independence. There are multiple possible contributors to the development of dementia, including genetic contributors, head trauma, alcohol, and vascular causes.

Regarding the diagnosis of dementia, although a number of definitions exist for dementia, the American Academy of Neurology and DSM-IV definition is widely accepted and includes the following:

- Evidence from the history and mental status examination that indicates major impairment in learning and memory as well as at least one of the following:

  - Impairment in handling complex tasks.
  - Impairment in reasoning ability.
  - Impaired spatial ability and orientation.
  - Impaired language.

- The cognitive symptoms must significantly interfere with the individual's work performance, usual social activities, or relationships with other people.
- This must represent a significant decline from a previous level of functioning.
- The disturbances are of insidious onset and are progressive, based on evidence from the history or serial mental-status examinations.
- The disturbances are not occurring exclusively during the course of delirium.
- The disturbances are not better accounted for by a major psychiatric diagnosis.
- The disturbances are not better accounted for by a systemic disease or another brain disease.

This patient does have cognitive impairment affecting multiple areas of function and should undergo neuropsychological screening.

Mr. [redacted] does have other symptoms suggesting injury to his nervous system:

HEADACHE:
There are two separate mechanisms for development of headache in this case:

- Head trauma can result in a long-term headache complaint. Headaches are variably estimated as occurring in 25 to 78 percent of persons following head trauma (Baandrup et al, 1999). Most post-traumatic headaches can be classified by IHS type similarly to non-traumatic headaches. In most series, tension-type (TTH) and migraine headaches are most frequent (Haas, 1996). This patient does not have a baseline headache complaint pre-dating the industrial injury and no family history of headache. It is also worth noting that in several neurodegenerative processes associated with football, including dementia, headaches are noted as a prominent feature (McKee et al, 2013).

- Mechanistically, this patient certainly could have developed these headaches associated with the pathology in his neck. There is ample evidence in the medical literature (Vernon et al, 1992; Watson et al, 2012) which link pathology in the cervical spine and the development/aggravation of headache.

TINNITUS/HEARING LOSS/DIZZINESS:

Tinnitus is a perception of sound in proximity to the head in the absence of an external source. It can be perceived as being within one or both ears, within or around the head, or as an outside distant noise. The sound is often a buzzing, ringing, or hissing, although it can also sound like other noises. There are multiple potential causes of this symptom that can be relevant to this case, but the most likely mechanism is trauma. Tinnitus may occur with barotrauma to the middle or inner ear (often associated with vertigo and hearing loss).

Head trauma can also result in disruption to the equilibrium apparatus of the inner ear. Post traumatic vertigo can include labyrinthine mechanisms. This can be due to direct injury to the cochlea and vestibular structures. Labyrinthine concussion may occur from blunt injury to membranous labyrinth against the otic capsule. This often resolves within months but can persist. Benign paroxysmal positional vertigo (BPPV) occurs after head injury that causes shearing displacement of the otoconia, which then settle to one of the semicircular canals.

Head/ear trauma can also result in hearing loss, particularly if there is trauma to the external auditory canal or meatus. Injury to CN 8 (vestibulocochlear nerve) can also result in hearing deficits.

There is a description in the literature of a helmet-to-helmet barotrauma occurring in a football player that resulted in an injury to the inner ear apparatus, supporting this mechanism occurring in football play

PLAN:

I will produce a supplemental report after getting the results of the neuropsychological testing.

Further studies, including neuroimaging, may also be required in this patient's case.

Please contact me with any questions.

MEDICAL RECORDS REVIEWED:

1. 1/3/04: Post-Season Physical Examination Summary Report - Cleveland Browns.

2. 4/29/04: Health History and Physical Examination Report - Cleveland Browns.

3. 4/30/04: Clinic Note - Robert Dimeff, M.D.

4. 4/30/04: Medical Examination Report - Illegible Signature, Cleveland Browns.

5. 5/1/04: Clinic Note – Mihir Jani, M.D.

6. 6/16/04: Clinic Note - Robert Dimeff, M.D. The patient is given hepatitis B #1.

7. 7/21/04: Interim Health and Physical Examination Report - Cleveland Browns.

8. 7/31/04: Injury Report - Cleveland Browns.

9. 8/1/04: Clinic Note - Robert Dimeff, M.D.

10. 8/1/04 to 10/21/4: PT Reports – Cleveland Browns.

11. 11/30/04: Medical Report – Cleveland Browns.

12. 1/3/05: Clinic Note – Brain Donley, M.D.

13. 6/8/05: Interim Health and Physical Examination Report - Cleveland Browns.

14. 6/9/05: Clinic Note – Paul Gubanich, M.D. and Robert Dimeff, M.D.

15. 6/9/05: Medical Note - Stop Kosmorsky, M.D.

16. 7/28/05: Interim Health and Physical Examination Report - Cleveland Browns.

17. 8/15/05 to 9/2/05: PT Reports – Cleveland Browns.

18. 8/25/05: Injury Report - Cleveland Browns.

19. 8/26/05: Clinic Note - Anthony Miniaci, M.D.

20. 9/1/05: Injury Report - Cleveland Browns.

21. 12/14/05: Medical Report - Cheryl Spinweber, M.D.

22. 1/13/06: Initial Evaluation Report - Valerie Stanton, P.T.

23. 2/7/06: Medical Report - Gary de Voss, Ph.D.

24. 2/9/06: Progress Note - Pierre Rivet, M.D.

25. 2/14/06: Consultation Report - Pierre Rivet, M.D.

26. 2/14/06: Operative Report - Pierre Rivet, M.D., San Diego Out-Patient Ambulatory Surgical Center.

27. 2/16/06: Progress Note - Pierre Rivet, M.D.

28. 2/21/06 and 3/1/06: Medical Notes - Pierre Rivet, M.D.

29. 3/23/06: Health History Report - Denver Broncos Football Club.

30. 3/23/06: Medical Report - Theodore Schlegel, M.D.

31. 4/4/06: Laboratory Report - LabCorp.

32. 4/4/06: Laboratory Report - SCRL.

33. 4/3/06: Injury/Illness Report – Denver Broncos Football Club.

34. 4/4/06 to 6/23/06: Injury Maintenance Report – Denver Broncos Football Club.

35. 8/9/06: Injury/Illness Report - Denver Broncos Football Club.

36. 8/9/06 to 8/23/06: Injury Maintenance Report - Denver Broncos Football Club.

37. 8/12/06: Medical Report - Kevin Charron, M.D.

38. 9/14/06: Injury/Illness Report - Denver Broncos Football Club.

39. 9/15/06: Medical Report - Martin Boublik, M.D.

40. 9/19/06: Operative Report - Martin Boublik, M.D., Centrum Surgical Center.

41. 9/20/06: Daily Progress Note - Steadman Hawkins Denver Clinic.

42. 9/20/06 and 9/25/06: Medical Reports - Martin Boublik, M.D.

43. 9/21/06 to 11/3/06: Injury Maintenance Report – Denver Broncos Football Club.

44. 10/10/06: Medical Report - Charles Lind, M.D.

45. 10/16/06: Medical Report - Martin Boublik, M.D.

46. 12/12/06: Medical Report (Incomplete Copy) - John Geraghty, M.D.

47. 2/12/07: Medical Note - Pierre Rivet, M.D.

48. 4/2/07: Laboratory Report - LabCorp.

49. 5/17/07: Orthopedic Examination Report - Denver Broncos Football Club.

50. 5/17/07: Medical Report - Charles Lind, M.D.

51. 11/6/07: Release Examination Report - Denver Broncos Football Club.

52. 3/27/08: Nutrition Note - Sue James, M.S.

53. 5/8/08: Interim Physical Questionnaire and Examination Report - Baltimore Ravens.

54. 5/9/08: Laboratory Report - MedStar Health.

55. 11/5/08: Health History Report - Tennessee Titans.

56. 12/21/08 to 12/24/08: Episode History Report - Tennessee Titans.

57. 1/1/09: Medical Report - J.W. Thomas Byrd, M.D.

58. 1/1/09 and 1/2/09: Episode History Report - Tennessee Titans.

59. 5/21/09: Progress Report - Paul Marchetto, M.D.

60. 5/21/09: Detailed History of Injury – Unknown Source.

61. 5/22/09: Player's Request for a Second Opinion - NFL.

62. 5/26/09: Progress Report - Russell Nord, M.D.

63. 5/27/09 to 7/21/09: Medical Reports - Gary Fanton, M.D.

64. 7/22/09: Initial Evaluation Report - Eric Schleicher, P.T.

65. 7/24/09 to 10/12/09: Physical Therapy Reports – Select Physical Therapy.

66. 10/15/09: Progress Report - Gary Fanton, M.D.

67. 10/15/09 to 2/16/10: Physical Therapy Reports – Select Physical Therapy.

68. 2/16/10: Medical Note - Pierre Rivet, M.D.

69. 3/25/10: Medical Report - Gary Fanton, M.D.

70. 5/4/10: Medical Note - Illegible Signature.

71. 5/18/10: Laboratory Report - Paul Cusick, M.D.

72. 7/20/10: Laboratory Report - Holy Cross Hospital Laboratory.

73. 7/20/10: Orthopedic Examination Report - Miami Dolphins.

74. 8/18/10: Physical Evaluation Report - Michael McAdam, M.D.

75. 8/20/10 and 8/26/10: Medication Notes - Jonathan Drezner, M.D.

76. 9/2/10: Evaluation Report - Michael McAdam, M.D.

77. 11/23/10: Medical History Update - Seattle Seahawks.

78. 12/16/10 and 12/20/10: Evaluation Reports - Michael McAdam, M.D.

79. 1/17/11: Pre/Post Season Physical Examination Report - Michael McAdam, M.D.

80. 1/21/11: Endodontic Case Report - Babak Shoushtari, M.D., La Jolla Endodontics.

81. 1/21/11: Prescription Note - Babak Shoushtari, M.D.

82. 8/6/11: Orthopedic Examination Report - Kansas City Chiefs Football Club, Inc.

83. 8/6/11: Laboratory Report - Heartland Regional Medical Center.

84. 8/6/11: Medical Note - Illegible Signature, Kansas City Chiefs Football Club, Inc.

85. 9/27/11: Medical Report - Babak Shoushtari, M.D.

86. 10/10/11: Laboratory Report - Quest Diagnostics

87. 1/3/12 to 5/9/12: Medical Reports - Cris Barnthouse, M.D.

88. 5/14/12: Orthopedic Examination Report - Kansas City Chiefs Football Club, Inc.

89. 6/11/12: Laboratory Report - Quest Diagnostics.

90. 6/18/12: Prescription Note - Oasis MSO, Inc.

91. 7/20/12: Medical Report - Orthopaedic Sports Medicine Clinic

92. 9/3/12: Medical Report - Cris Barnthouse, M.D.

93. 9/4/12: Medical Report - James Voos, M.D.

94. 9/21/12: Comprehensive Progress Note - Jafri Rachna, M.D.

95. 5/22/13: Neutral Physical Examination Report - David Lowenberg, M.D.

96. 6/11/13: Medical Report - David Chao, M.D.

REVIEW OF DIAGNOSTIC STUDIES

1. 9/29/00: MRI of the Right Shoulder - Christopher Beaulieu, M.D., Stanford Hospital.

2. 4/10/01: X-rays of the Right Elbow - Christopher Beaulieu, M.D., Stanford Hospital.

3. 4/23/01: X-rays of the Right Elbow - Barton Lane, M.D., Stanford Hospital.

4. 6/3/01: X-rays of the Right Elbow - Philipp Lang, M.D., Stanford Hospital.

5. 11/26/01: X-rays of the Right Shoulder - Glenn Strome, M.D., Stanford Hospital.

6. 4/19/02: X-rays of the Right Ankle - Peter Kane, M.D., Stanford Hospital.

7. 8/28/02: X-rays of the Left Elbow - Henry Jones, M.D., Stanford Hospital.

8. 9/17/02: X-rays of the Left Index Finger - Christopher Beaulieu, M.D., Stanford Hospital.

9. 10/8/02: X-rays of the Left Hand - Christopher Beaulieu, M.D., Stanford Hospital.

10. 10/24/02: X-rays of the Left Hand - Kathryn Stevens, M.D., Stanford Hospital.

11. 9/1/03: X-ray of the Chest - Dominik Fleischmann, M.D., Stanford Hospital.

12. 9/11/03: X-ray of the Chest - Garry Gold, M.D., Stanford Hospital.

13. 4/30/04: X-ray of the Chest - Bradford Richmond, M.D., Cleveland Clinic Strongsville.

14. 4/30/04: X-rays of the Right Shoulder - Bradford Richmond, M.D., Cleveland Clinic Strongsville.

15. 4/30/04: ECG Report – Unknown Source.

16. 8/1/04: X-rays of the Right Ankle - George Belhobek, M.D., Cleveland Clinic.

17. 4/21/05: CT of the Sinuses without Contrast - Doksu Moon, M.D., Cleveland Clinic Strongsville.

18. 6/9/05: ECG Report- Cleveland Clinic Strongsville.

19. 8/25/05: MRI of the Left Knee without Contrast - Hakan Ilaslan, M.D., Cleveland Clinic Strongsville.

20. 9/2/05: X-rays of the Left Hand and Thumb - Bradford Richmond, M.D., Cleveland Clinic Strongsville.

21. 9/14/05: X-rays of the Left Thumb - Peter Yee Tun Wu, M.D., Cleveland Clinic Strongsville.

22. 12/9/05: Polysomnography Report - Cheryl Spinweber, M.D., Scripps Mercy Hospital.

23. 4/5/06: Echocardiographic and Hypertensive Assessment Report - Jeffrey Boone, M.D.

24. 5/18/06: ECG Report - Presbyterian/St. Luke’s Medical Center.

25. 4/3/07: Echocardiographic and Hypertensive Assessment Report – Jeffrey Boone, M.D., The Boone Heart Institute.

26. 5/22/09: MRI of the Left Ankle without Contrast - Adam Zoga, M.D., Jefferson Outpatient Imaging.

27. 8/6/11: X-rays of the Left Knee - Jack Bridges, M.D., Heartland Health Radiology.

28. 8/6/11: X-rays of the Right Knee - Jack Bridges, M.D., Heartland Health Radiology.

29. 8/6/11: X-rays of the Knees - Jack Bridges, M.D., Heartland Health Radiology.

30. 8/6/11: ECG Report - Unknown Source.

31. 8/6/11: X-ray of the Cervical Spine - Jose Alvarez, M.D., Heartland Health Radiology.

32. 8/6/11: X-ray of the Left Thumb - Jack Bridges, M.D., Heartland Health Radiology.

33. 8/6/11: X-ray of the Right Shoulder - Jack Bridges, M.D., Heartland Health Radiology.

34. 8/6/11: X-ray of the Chest - Jack Bridges, M.D., Heartland Health Radiology.

35. 8/6/11: ECG Report - Mohan Hindupur, M.D.

36. 8/6/11: X-rays of the Right Elbow - Jack Bridges, M.D., Heartland Health Radiology.

37. 8/6/11: X-rays of the Left Ankle - Jack Bridges, M.D., Heartland Health Radiology.

38. 1/3/12: MRI of the Left Shoulder without Contrast - Hollis Fritts, M.D., CDI.

39. 1/3/12: MRI of the Right Knee without Contrast - Hollis Fritts, M.D., CDI.

40. 1/3/12: MRI of the Left Knee without Contrast - Hollis Fritts, M.D., CDI.

41. 9/3/12: MRI of the Right Knee without Contrast - Kavita Gorantia, M.D., Alliance Radiology, P.A.

42. 2/25/13: MRI of the Cervical Spine - Michael Smith, M.D., Advance Physicians MRI & Imaging Centers.

43. 2/25/13: MRI of the Brain without Contrast - Michael Smith, M.D., Advance Physicians MRI & Imaging Centers.

44. Undated: ECG Report - Illegible Signature.

45. Undated: ECG Report - Unknown Source.

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Regarding this report:

- I certify under penalty of perjury that the information provided is true and correct.
- I certify under penalty of perjury that the diagnosis being made consistent with the criteria provided.
- I certify under penalty of perjury that I am a board certified neurologist with the expertise to evaluate this patient.

Signed in Los Angeles County, California

By_____
Ezekiel Fink, MD, QME
Board Certified in Neurology and Pain Medicine
Diplomat, American Board of Psychiatry & Neurology